United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510–6275

BRUCE A. COHEN, *Chief Counsel and Staff Director*
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April 24, 2012

**Transmitted Electronically**
Ms. Lynne M. Halbrooks
Acting Inspector General
Department of Defense
4800 Mark Center Drive
Alexandria, VA 22350-1500

Dear Acting Inspector General Halbrooks:

I am writing to you today to express grave concern about the findings contained in an Office of the Inspector General (OIG) "Assessment Report," dated May 16, 2011. This internal review examined 169 military whistleblower cases handled by the Military Reprisal Investigations (MRI) directorate.

This report, which was just brought to my attention, is an excellent, hard-hitting example of self-examination. It may be the best OIG internal review I have ever seen. Those responsible for producing it deserve praise and encouragement for their professionalism, courage, and dedication to the IG's core mission. However, like the fine audits I recently brought to Secretary Panetta's attention, this report will surely go to waste unless there is accountability and meaningful corrective action. It is my understanding that neither has happened so far. Without your intervention, this report appears to be on a fast-track to the dust bin of history. In fact, that is exactly where it would be today were it not provided to the press. So long as the dysfunctional MRI process is swept under the rug, statutory protections for military whistleblowers will remain largely ineffective and compromised, leaving the door wide open to unrestrained reprisal.

What I find so disturbing about the internal review is the extent to which MRI bungled so many military whistleblower cases. According to the report, MRI was wrong over 50% of the time. It appears to suggest that OIG officials knowingly ignored the law and showed disrespect for military whistleblowers and the core IG mission. Because of these lapses, investigative misconduct is alleged. Taken together, this report provides evidence of a disgraceful failure of oversight – a failure caused by the watch-dogs in-charge of MRI. Two things need to happen now. First, heads must roll. Second, the root cause problems identified in this report must be addressed and resolved immediately. I also urge you to consider undertaking a re-examination of all the cases to determine if prohibited personnel actions were taken against whistleblowers with the knowledge and acquiescence of OIG investigators. OIG's failure of oversight may have caused irreparable damage to the careers of men and women serving in the Armed Forces – brave souls who stepped forward to report abuses thinking their communications were protected by law. Those cases deserve a second look to explore all available options for remedial action. Whistleblowers adversely affected by such lax oversight deserve nothing less.

In order to help me gain a full understanding of what happened and who is responsible and what is being done to correct the problem, I respectfully request that you provide me with answers to the attached list of 16 questions.

There is a long history at the OIG of failed attempts to reform the MRI process. I am referring to a string of reports, stretching back at least four years, that call for MRI reform. These include my in-depth staff oversight investigation of the Hudson case [October 2008]; the review by the Department of Justice OIG [July2009]; direction from the Armed Services Committees of the House and Senate [October 2009]; and the mandated report by the Government Accountability Office [February 2012]. These are all about the need to strengthen protections afforded military whistleblowers under the law. I call your attention to the not so spotless MRI track record because it speaks to a continuing reluctance on the part of the OIG to do what must be done.

Unless and until the OIG – under your leadership – is willing to "bite the bullet" and accept the very valid and justified recommendations contained in all these reports and convert them into concrete action, promised reforms will amount to nothing more than window dressing. The first step must be accountability. The second step must be meaningful corrective action. Take those two difficult steps and reform will surely follow.

I request a response in writing to the attached questions by Monday, May 14, 2012.

Sincerely,

Chuck Grassley

Charles E. Grassley
Ranking Member

Attachment

**Questions**

1) On May 16, 2011, the Office of the Inspector General (OIG) completed an "Assessment Report" that examined 169 military reprisal cases handled by the Military Reprisal Investigations (MRI) directorate in fiscal year 2010. This review was led by the Principal Deputy Inspector General (IG). Was this report subjected to a legal sufficiency review by the OIG Office of General Counsel? If not, why? Who approved the final report? Who is responsible for follow-up action?

2) Given the seriousness of this report's findings, were supervisors and managers subjected to administrative review or other corrective actions for their failure to adhere to statutorily-required system that was enacted to protect the uniformed whistleblowers of our Armed Services?

3) Who is chiefly responsible for the egregious oversight failures cited in this report? Has this person or persons been held accountable? If not, why?

4) Please provide a comparative matrix of issues raised in my staff's oversight review, the Justice Department review of MRI, the MRI internal review, and the GAO Report. Give the dates of these reviews, the issues they raised, the actions taken to correct the deficiencies identified in these reviews, and the current status of all those actions. Note in one of the columns, where each issue was identified in the appropriate Semi-Annual Report to the Congress. If the issue was not reported in the Semi-Annual Report to Congress, then state why.

5) My staff requested a copy of the MRI internal review on March 6, 2012. Your office provided my staff with an incomplete copy of this report on March 28, 2012. In transmitting the report, your office omitted three critical appendices – E, F, and G. After discovering this omission, my staff made a second request for the full report on April 12th. The missing documents were finally provided on April 19th. Why were those documents excluded from the original OIG submission of March 28th?

6) As I understand it, the GAO, which was conducting a review of the MRI process at my request, first asked for the OIG internal report on April 29, 2011, as its report was nearing completion. The GAO's initial request was followed by regular monthly requests. The final report -- with appendices -- was not provided to the GAO until December 2011 as its report was going to the printers for publication. Had your office provided this report in its entirety in a more timely fashion, the GAO might have heen able to provide me with a more probing and relevant piece of work. Who was responsible for withholding critical MRI case information from the GAO for at least 7 months?

7) A careful examination of these appendices may show that investigative misconduct occurred in some of the MRI cases examined. The report itself appears to identify cases in which alleged investigative misconduct took place. Have those cases been reviewed for possible reinvestigation? Have the complainants been notified that their complaints were mishandled? If not, why? Which cases do you intend to reinvestigate? Please provide the OIG plan for resolving all the issues involved. That plan should also include a review of the need for accountability if investigative misconduct did, in fact, occur?

8) Please provide copies of any high-level instructions or directives regarding the need to resolve case discrepancies, like the ones cited in Appendices E, F, and G?

9) In my oversight review of the investigation of reprisal actions taken against a whistleblower in the Department of the Navy's recruiting command[1], MRI's oversight process was found to be severely compromised. The findings and recommendations contained in my staff review of this matter were provided to your office on October 23, 2008. That was over two years before the Principal Deputy IG officially launched the internal review, which uncovered even more pervasive and egregious oversight failures. Now, we are nearly four years down the road from the Hudson report, and there still appears to be no meaningful reform of the MRI process. Please explain the apparent lack of progress? When will real reform happen? Why is there no sense of urgency?

10) What performance metrics are in place to measure the progress of reform?

11) Under 10 U.S.C. 1034, MRI is required to conduct investigations. At some point, between 2000 and 2010, a specific decision was made to stop conducing independent investigations of military whistleblower cases and to rely instead on oversight of investigations conducted by the service IG's. Who was in charge of MRI, Administrative Investigations, Policy & Oversight and Investigations, when these decisions were made? Who made that decision? Who reviewed the decision? Did the Inspector General endorse this decision? In light of the internal OIG MRI review, wouldn't it be prudent to review and reconsider this very questionable decision? Please provide all relevant documents bearing on this decision?

12) For the period of 2000 to 2010, please provide the number of reprisal reports of investigation issued by your office, broken down into Semi-Annual Reporting periods. List the reports by the following categories: uniformed, intelligence and counter-intelligence; civilian appropriated-fund, intelligence, non-appropriated fund; and contractor. If you have mental health referral cases in which the referral was made on a whistleblower, break those out in a separate category?

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[1] This is the MRI case of Navy Lieutenant Jason Hudson in the Navy Recruiting Command's Nashville, TN office;

13) How has the management of oversight cases changed since the internal review was completed? How many oversight actions has MRI performed in the past year? How many of those have been selected for investigation by MRI? How many Service IG findings were reversed by MRI? What feedback was sent to the Service IGs when their investigative work failed to meet required standards? Please summarize all such feedback over the past year, the nature of deficiencies detected including any recurring pattems, and the actions taken by the service IGs in response to OIG oversight?

14) With respect to performance of the new Whistleblower Reprisal Investigations directorate, how many investigators are now employed compared to 2008 in comparable areas? How many reports of investigation are they issuing per semi-annual reporting period? How many investigations per investigator per year does that equal? What is the current budget for this unit as compared to 2008-11?

15) Of the investigations completed in the past year, how many substantiated reprisal? What is the substantiation rate? How many resulted in remedial action on behalf of whistleblowers? How many resulted in disciplinary or administrative action against supervisors or managers? Please breakdown these statistics into the following categories: uniformed, intelligence and counter-intelligence; civilian appropriated-fund, intelligence; non-appropriated fund; and contractor. If you have mental health referral cases in which the referral was made on a whistleblower, break those out in a separate category.

16) Who is the final approval authority on all whistleblower reprisal case reports? What role does the Office of Professional Responsibility play in that process? Who heads that office, and has he or she reviewed the MRI internal review and all other pertinent documents and become thoroughly familiar with their findings and recommendations? Why has that office not acted on the MRI internal review?